



## ***Performance Report*** ***Performance Period October 2003-December 2003***

### **Introduction**

This report presents second quarter of fiscal year 2004 (October 2003-December 2003) information about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD). It is based on the most current data available. Where possible, data are aggregated at both statewide and district or complex levels.

Data for CAMHD are collected in four major areas: Population, Service, Cost, and Performance Measures. Population information describes the characteristics of the children, youth, and families that are served. Service information is compiled regarding the type and amount of direct care services that are used by children, youth, and families. Cost information is gathered about the financial aspects of services. Performance Measures, including Outcome data, are tracked to understand the quality of services and the performance of operations of the statewide infrastructure needed to provide supports for children, youth, and families. Outcomes are further examined to determine the extent to which services provided lead to improvements in the functioning and satisfaction of children, youth and families.

### **Criteria for Establishing Measures**

CAMHD Performance Measures were initially established to gauge compliance with the Felix Consent Decree. By December 2002, all CAMHD Benchmarks reported to the Court were deemed to be “completed” or “completed and ongoing.” Tracking of a subset of CAMHD Performance Measures are tied to demonstrating sustainability with the gains made during the Felix Consent Decree. The specific Benchmarks and reports to the Court were:

- 1) CAMHD outcome and results components will be implemented (Benchmark 22),
- 2) CAMHD will have developed appropriate CSPs for all children whose care is coordinated by CAMHD (Benchmark 26),
- 3) Service gap analysis (unserved youth report) will document that no child will wait longer than 30 days for a specified service or appropriate alternative...CAMHD will document in the quality improvement reviews that appropriate referrals are being made (Benchmarks 33 and 54-deemed completed),
- 4) Personnel and Vacancy Reporting,
- 5) Benchmarks that describe complex-based service testing, and
- 6) Complaints (no Benchmark attached, reporting requested by the Felix Monitoring Project).

The second standard for choosing CAMHD Performance Measures aligns CAMHD performance with achieving results in core areas of service provision and supporting infrastructure. Measures help to coordinate work targeted at achieving timely, cost-effective services that improve the lives of children, youth and families served. Not all indicators link directly to former Court Benchmarks, but rather are measures that reflect a sustainable and effective system of children's mental health services.

## Use of Performance Data in CAMHD

### *Decision-making and aligning work with improvement objectives*

Performance measurement serves to:

1. Communicate the objectives and overall performance requirements of CAMHD's strategic goals throughout its organization and to its stakeholders.
2. Provide data-driven information that allows for the evaluation of quality and results through objective data.
3. Organize work around objectives, and promote accountability for organizational performance results.
4. Inform decisions about services and adjustments to program implementation. Because performance data in CAMHD are continuously tracked and readily available, decisions potentially can be made quickly and accurately, a key advantage in serving youth with intensive mental health issues.
5. Inform continuous improvement efforts at all levels. Performance reporting about client status, care and service delivery is assessed to determine priorities for improvement, including areas that would benefit from focused study. CAMHD's internal quality management structure, the Performance Improvement Steering Committee (PISC) and its subcommittees regularly receive performance data and reports regarding the quality and effectiveness of care across the service system. They then develop recommendations for improvements, which are monitored for implementation, and evaluated for impact.
6. Allow for decision support and clinical analysis through the use of "live" data from the Child and Adolescent Mental Health Management Information System (CAMHMIS). Relevant client-related data including functional outcomes, service history, and current interventions are available in profile format, which assists Care Coordinators and teams in service planning.
7. Provide feedback to staff regarding performance. At both the Central CAMHD Office and the Family Guidance Centers (FGCs), Branch Chiefs and supervisors are able to access timely data relevant to unit and staff performance. Local-level managers are also able to monitor regional and statewide trends and performance expectations, which further supports planning and decisions.

The use of data and a focus on results has become a CAMHD organizational value, and is evident in daily operations at all levels. Performance measure selection and tracking is now entering its fourth full year of implementation in all units of the organization. This has allowed staff to link their own work processes to strategic outcomes and results. Performance measurement also extends to the CAMHD provider network, which systematically track performance data on selected functions.

## Data Sources

The primary source for data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through CAMHMIS. CAMHMIS has the ability to produce data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data as earlier described, FGC-specific reports and a host of special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

## Population Characteristics

Population data reflect the second quarter of fiscal year 2004 (October-December 2003) for youth registered in the CAMHD Family Guidance Centers. In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,662 youth across the State, an increase of 20 from the previous reporting quarter (July-September 2003), or a .01% increase in the total population.

The total number of registered youth are described by four subgroups: (i) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (ii) youth who were in the process of having services arranged (new admissions), (iii) youth who received less intensive services through Mokihana on Kauai, and (iv) youth who were discharged at some time during the quarter. There was also a percentage of youth who received intensive case management services only. Of the total registered youth, 861 had services that were authorized within the quarter.

Of the registered population (1,662), 126 youth (7.6%) were newly registered in the second quarter of fiscal year 2004. This represents an increase of 45 new admissions from the first quarter. One hundred fifty one (151) youth (9.1%) who had previously received services from CAMHD were reregistered in CAMHMIS, an increase from last quarter's readmissions of 93 youth. CAMHD discharged a total of 227 youth during the quarter, or 13.7% of the registered population. This is an increase from last quarter's discharge of 164 youth (10% of the registered population).

Of the 861 youth who had services authorized in the quarter, 53 were new admissions (6.2%), 65 repeat admissions (7.5%) and 71 discharges (8.2%). It is important to note that because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size.

The average age of youth registered in the reporting quarter was 14.4 years with a range from 3 to 20 years. As displayed in Table 1, the majority of the youth were male (68%). These demographics have been fairly consistent over time.

Table 1. Gender of CAMHD Youth

Gender	N	% of Available
Females	536	32%
Males	1,126	68%

A large percentage of youth who receive case management and direct services through CAMHD are involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 2). Of the youth who had services authorized in the quarter, 15.3% were involved with DHS, 36.6% had a Family Court hearing during the quarter, and 10.5% were incarcerated at HYCF or detained at the Detention Home. QUEST-eligible youth who received services in the quarter were 38.8% of the population who received services. CAMHD continues to receive Federal Medicaid reimbursement to provide

Table 2. Agency Involvement of Youth with Authorized Services

Agency Involvement	N	%
DHS	132	15.3%
Court	315	36.6%
Incarcerated/Detained	90	10.5%
SEBD	89	10.3%
Quest	334	38.8%

behavioral health services within the CAMHD array of services under the Medicaid state plan for rehabilitative services. A key provision of the Memorandum of Agreement with the Med-QUEST Division allows any QUEST-eligible youth with Severe Emotional and Behavioral Disturbance to receive services through CAMHD.

Table 3 describes the various ethnicities of youth who received authorizations for services in the reporting quarter. Those with Mixed ethnicities represented the largest group (31.9%), followed by youth of Hawaiian ethnicity (22.4%). Caucasian made up the third largest ethnic group (19.3%), followed by Filipino (7.2%) and Japanese (5.4%).

Table 3. Ethnicity of Youth with Authorized Services

<b>Ethnicity</b>	<b>N</b>	<b>% of Available</b>
African-American	20	2.7%
African, Other	1	0.1%
American Indian	2	0.3%
Asian, Other	5	0.7%
Caucasian, Other	144	19.3%
Chamorro	1	0.1%
Chinese	5	0.7%
Filipino	54	7.2%
Hawaiian	167	22.4%
Hispanic, Other	10	1.3%
Japanese	40	5.4%
Korean	2	0.3%
Micronesian	4	0.5%
Mixed	238	31.9%
Pacific Islander	11	1.5%
Portuguese	15	2.0%
Puerto Rican	8	1.1%
Samoan	19	2.5%
Not Available	115	13.4%

Table 4. Diagnostic Distribution of Youth with Authorized Services

<b>Any Diagnosis of</b>	<b>N</b>	<b>%</b>
Disruptive Behavior	441	51.2%
Attentional	349	40.5%
Mood	339	39.4%
Miscellaneous	222	25.8%
None Recorded	198	23.0%
Anxiety	150	17.4%
Substance-Related	140	16.3%
Deferred	102	11.8%
Adjustment	83	9.6%
Mental Retardation	19	2.2%
Pervasive Developmental	5	0.6%

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 4). Thus, the reported percentages may exceed 100% because youth might receive diagnoses in multiple categories. The top three diagnoses of youth with authorized services in the quarter were disruptive behavior disorders (51.2%),

attentional disorders (40.5%), and mood disorders (39.4%). This diagnostic breakdown has been fairly consistent over time.

Those youth with miscellaneous diagnoses account for 25.8% of the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control and eating disorders. Many youth in the population have co-occurring, or more than one diagnosis. In the reporting quarter 67.9% of registered youth had more than one diagnosis, with an average of 2.0 diagnoses per youth (median=2.0). Youth with substance-related diagnoses represent 16.3% of the population, a slight increase from last quarter's data of 15.2%. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use as a target of intervention.

## Services

Tracking of utilization of the services within the CAMHD array allows for accurate accounting and data-driven planning and decision-making. Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. On the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (October-December 2003). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, the largest percentages of youth served were authorized to receive services provided in the home and/or community, which consist of Intensive In-home services (46.7%) and Multisystemic Therapy (12.9%). The largest group of youth in an out-of-home setting received services in a Community-based Residential program (18.5%). Youth receiving treatment while in Therapeutic Family Homes accounted for 13.7% of those served, and Therapeutic Group Homes 10.6%.

Table 5. Service Authorization Summary (October 1, 2003-December 31, 2003).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	5	6	0.4%	0.7%
Hospital Residential	20	31	1.9%	3.6%
Community High Risk	9	9	0.5%	1.0%
Community Residential	124	159	9.6%	18.5%
Therapeutic Group Home	73	91	5.5%	10.6%
Therapeutic Family Home	103	118	7.1%	13.7%
Respite Home	1	2	0.1%	0.2%
Multisystemic Therapy	80	111	6.7%	12.9%
Intensive In-Home	326	402	24.2%	46.7%
Flex	106	160	9.6%	18.6%
Respite	22	25	1.5%	2.9%
Less Intensive	28	54	3.2%	6.3%
Crisis Stabilization	3	8	0.5%	0.9%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

Flex services were provided for 18.6% of youth served. Flex services are a broad category that range from mental health services not provided through a regular purchase of service contract, to travel for youth in off-island residential programs, to interpretive services. The pattern of relatively few families receiving Respite services continued to have relatively low utilization with only 2.9% of the served population receiving an authorization for this service in the reporting quarter.

## Cost

CAMHD uses several sources to produce information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the first quarter of fiscal year 2004 (July 1, 2003-September 30, 2003). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 6. Out-of home residential treatment services in Hawaii, including hospital-based residential treatment accounted for 82.9% of service expenditures. This compares to out-of home service accounting for 83.4% of the total costs in the first quarter of FY 2004, or a .5% decrease in percentage of total expenditures. Youth in out-of-state treatment settings accounted for only 1.3% of total expenditures.

Table 6. Cost of Services

Any Receipt of Services	Total Cost (\$)	Cost per Youth (\$) <sup>a</sup>	Cost per LOC (\$) <sup>b</sup>	Cost per LOC per Youth (\$) <sup>b</sup>	% of LOC Total (\$) <sup>b</sup>
Out-of-State	118,468	19,745	117,299	19,550	1.3%
Hospital Residential	694,402	31,564	508,990	23,136	5.5%
Community High Risk	412,613	41,261	402,930	40,293	4.3%
Community Residential	4,017,967	25,922	3,502,533	22,597	37.5%
Therapeutic Group Home	2,105,964	21,937	1,773,891	18,478	19.0%
Therapeutic Family Home	1,894,566	15,658	1,546,858	12,784	16.6%
Respite Home	1,723	1,724	403	403	0.0%
Multisystemic Therapy	706,139	5,231	438,374	3,581	5.2%
Intensive In-Home	1,593,557	4,354	823,482	2,250	8.8%
Flex	3,636,105	20,660	144,366	820	1.5%
Respite	118,625	4,394	17,486	648	0.2%
Less Intensive	190,624	19,062	8,094	809	0.1%

Note: <sup>a</sup> Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care. <sup>b</sup> Cost per LOC represents unduplicated cost for services at the specified level of care.

Hospital-Based Residential Services experienced a decreased cost in the reporting quarter, as did Community-Based Residential Services. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth (\$41,261 per youth, with an average of \$40,293 per youth expended for Community High-Risk Services only). For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes (\$15,658 per youth).

In-Home (Intensive In-Home and MST) and less intensive services accounted for 14% of the unduplicated cost of services, which was slightly higher than the last reporting quarter (July-September 2004) percentage of total costs for those categories. Youth receiving Intensive In-Home services at some point during the quarter cost an average of \$4,354 per youth (\$2,250 for Intensive In-Home service only), which continues to be significantly less than the cost per any youth in a residential program. Historically, average Intensive In-home expenditures have tended to approximate MST averages, while total costs tend to exceed MST total costs due to the larger number of served youth.

Youth who received Flex services during the quarter had a cost of \$20,660 per youth, or a cost just in this level of care of \$820 per youth. The average cost per youth for a child receiving Flex at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for flex services suggest that youth in out-of home placements account for a high percentage of youth receiving flex services.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and Family Guidance Centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

## Services for Youth With Developmental Disabilities

As reported in October, the Memorandum of Agreement (MOA) between CAMHD and Developmental Disabilities Division (DDD) to continue the provision of services, supports and coordination for youth with mental retardation and/or developmental disabilities was executed in July 2003.

### *Respite Services*

For October, November, December, DDD continued to meet respite needs of the target population through the DDD service system. DOH case managers assisted families to transition to other service options such as DDD Respite (via open enrollment), home and Community-Based Services – DD/MR (HCBS-DD/MR) waiver program, and other DDD funded supports such as our Purchase of Service (POS) Partnerships in Community Living (PICL). The table below shows updated utilization of various DDD services that families accessed to meet their needs.

Table 7. Other Service Options Utilized by CAMHD Respite Recipients

DDD Service	# of Users
*HCBS - DD/MR Waiver	37
**POS - Partnerships in Community Living (PICL)	69
***DDD Respite	55
Family Support Services Program (FSSP)	11

\* Waiver admission as of 1/15/04

\*\* PICL referrals for period 10/01/03 – 12/31/03

\* \*\*DDD Respite (CAMHD recipients who applied for DDD Respite in December 2003)

In summary, of the original 205 youth, 132 families (123 from the original list plus 9 “add-ons”) or 64% were identified by DDD as eligible and in a position to receive respite supports.

Table 8. Expenditures to Date for CAMHD Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	\$146,775.18	46%	\$2,010.62
Hawaii	34	26%	\$89,564.00	28%	\$2,634.24
Kauai	11	8%	\$54,174.50	17%	\$4924.95
Maui	14	11%	\$27,258.00	9%	\$1947.00
Total Youth	132	Total Dollars Expended (July 2002-December 2003)			\$317,771.68

As expected, while families accessed DDD service options, respite expenditures for the period October, November and December decreased significantly. The total dollars expended for the target population since July 2002 is \$317,771.68.

DDD continued to communicate with families regarding the transition of CAMHD Respite into the DD service system; final letters to families regarding the sunset of CAMHD Respite were mailed in December 2003.

### *Residential Services*

There are currently ten youth being served in the Individual Community Residential Support (ICRS) contract. To date, all but one out of ten youth served in the current contract have been admitted to the HCBS DD/MR waiver program. The youth who is not in waiver is in a hospital-based residential setting.

All ten youth covered in the current contract continue to live in the same settings. The most recent provider (Child and Family Services) and Case Manager reports indicate consistent school attendance in almost all cases. One youth did not attend school for a short period of time but the case manager has since coordinated a start date effective January 2004 at a new school.

The current ICRS contract with Child and Family Service (CFS) is for \$986,390.00. The DDD is planning to terminate this contract in June 2004. Case managers are currently working with each youth and the provider to plan for residential needs and continue community-based supports. Except for residential needs, 9 of the youth's long term supports will be met through the HCBS DD/MR waiver program. CFS and DDD have targeted March 2004 as the timeline to identify all residential supports for all of the youth, well before the end of the contract. One youth, who is in the hospital-based residential setting, needs continued psychiatric treatment services, and a plan will be developed to address how to best provide necessary supports for this child.

### *Joint Training Initiative*

Based on last year's monitoring, joint training between CAMHD and the DDD on Youth with Sexualized Behaviors has been scheduled for early March. Over 50 DDD staff are registered for the training. After the initial training, trainers will further tailor training for the DD population especially in regards to behavioral and cognitive requirements.

### *Overall Supports for the Population*

DDD's contract with a developmental and behavioral pediatrician from Kapiolani Medical Specialists provides for the opportunity of medical residents from various specialties to provide consultation, education and training to DOH/DDD case managers and stakeholders. For this upcoming year, this contract will include a focus on developing the "medical home" to address transition of children with DD/MR from pediatric/adolescent specialists to adult medical specialists. The development of this "medical home" model for these young adults will involve the participation of local physicians to identify training and support needs for physicians to ease this vital transition.

Previously, the Division had hired a psychologist with specialty skills in working with children with challenges. To augment the Division's capacity to meet the needs of challenging individuals, particularly those transitioning out of the education system into the adult service system, an interdisciplinary case management team has been formed to address transition assessment, service planning, and provider capacity. This interdisciplinary case management team includes the psychologist as lead, case managers for these individuals, as well as a clinical nurse consultant, psychiatrist, and developmental pediatrician.

A secondary goal for this team is to work to strengthen the interagency collaborative efforts between the behavioral health services administration as well as to develop closer working relationships with community physicians and other mental health professionals.

## Performance Measures

CAMHD uses performance measures to demonstrate sustainability and adequacy of services, results, infrastructure, and key practice initiatives. They measure the ability to maintain gains made since the inception of the Felix Consent Decree, and achieve CAMHD practice standards. CAMHD has set performance goals for each measure. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

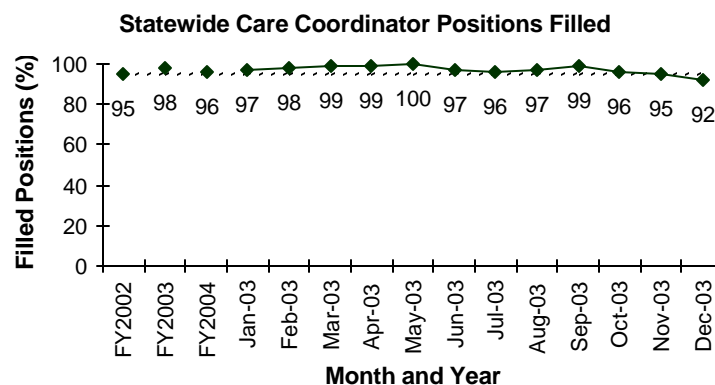
Those performance measures linked to previous Court Benchmarks are noted by an asterisk (\*).

*CAMHD will maintain sufficient personnel to serve the eligible population*

**Goal:**

⇒ *95% of mental health care coordinator positions are filled\**

Over the reporting period, CAMHD had an average of 94.3% of care coordinator positions statewide filled, which was just short of the performance goal. This quarter's data reflects the first time the performance goal was not met since this indicator was reported at the start of FY 2002. Although the goal was met for the first two months of the quarter, vacancies on the Big Island, which currently has three care coordinator vacancies, impacted the Statewide data for the quarter. These positions are under active recruitment.

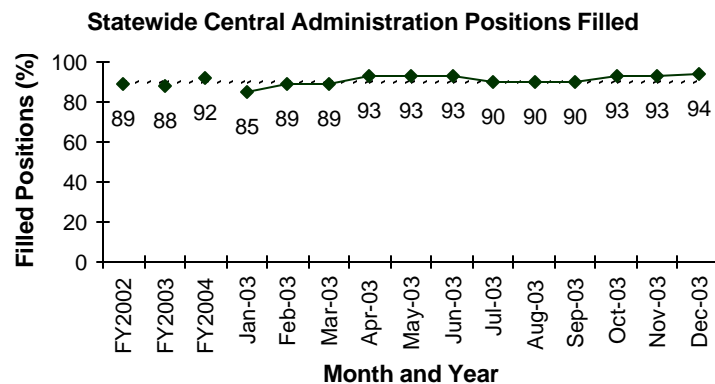


**Goal:**

⇒ *90% of central administration positions are filled\**

The performance target was met with an average of 93% of central administration positions filled over the quarter. Central Administration positions provide the infrastructure and quality management functions necessary to manage the statewide service system. This quarter's data

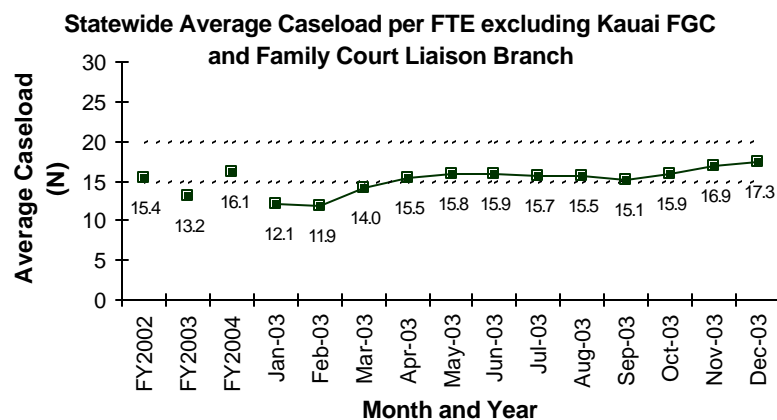
represents the largest percentage of CAMHD Central Administrative positions filled since the start of tracking this measure in FY 2002.



**Goal:**

⇒ *Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.*

The average caseload for the second quarter was within the target range at 16.7 youth per full time care coordinator equivalent (FTE). CAMHD expects that care coordinator caseloads fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services.



The average caseloads were met for all FGCs with the exception of Honolulu FGC. This calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads.

## Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
2 <sup>nd</sup> Quarter Average	20	15	19	16	14	18

Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

*CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight*

**Goal:**

⇒ Sustain within quarterly budget allocation

In the reporting quarter, the total variance from the budget was under projection by \$33,000. CAMHD continued its trend of sustaining below the budget allocation in the quarter. Central Office expenditures were below budget. Service expenditures and Family Guidance Centers' expenditures were higher than budgeted. As can be seen in the table below, service expenditures for the previous two quarters and FGC Branch expenditures for the previous three quarters were substantially lower than the quarterly budget allocation.

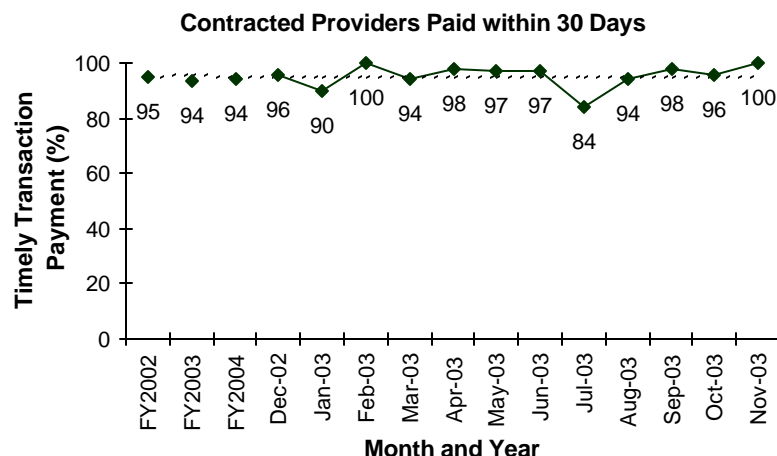
	Variance from Budget (in \$1,000's)							
	FY 2002	FY 2003	FY 2004					
	Average	Average	Average	2003.1	2003.2	2003.3	2003.4	2004.1
Branch Total	\$164	-\$150	\$134	\$66	-\$195	-\$312	-\$162	\$134
Services Total	\$798	-\$4,175	\$59	\$315	\$2	-\$16,251	-\$765	\$59
Central Office Total	-\$189	-\$388	-\$226	-\$833	-\$216	-\$352	-\$151	-\$226
Grand Total	\$773	-\$4,713	-\$33	-\$452	-\$408	-\$16,915	-\$1,078	-\$33

*CAMHD will maintain timely payment to provider agencies*

**Goal:**

⇒ 95% of contracted providers are paid within 30 days

The target goal was met for the quarter with 98% of contracted providers paid within the 30-day target. This was an improvement over last quarter. As standard for reporting, data is only available for the months of October and November, as December's payments are still in mid-cycle.



*CAMHD will provide timely access to a full array of community-based services*

**Goal:**

⇒ 98% of youth receive services within thirty days of request\*

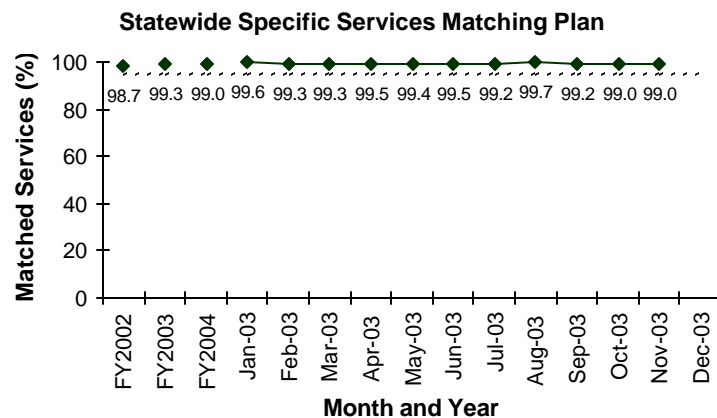
The goal was met for the quarter with 100% of youth were provided timely access to services. The last reported service gap was in August of 2001.



**Goal:**

⇒ 95% of youth receive the specific services identified by the educational team plan\*

CAMHD continued to demonstrate strong performance on this measure. In the quarter 99% of youth received the specific services identified by their team plan. In the second quarter, service mismatches occurred in ten complexes. These youth received services within 30 days, but they were not the exact service prescribed by their IEP teams.



One complex, Baldwin, had four mismatches. Baldwin also experienced a number of mismatches in the previous two quarters (four in the first

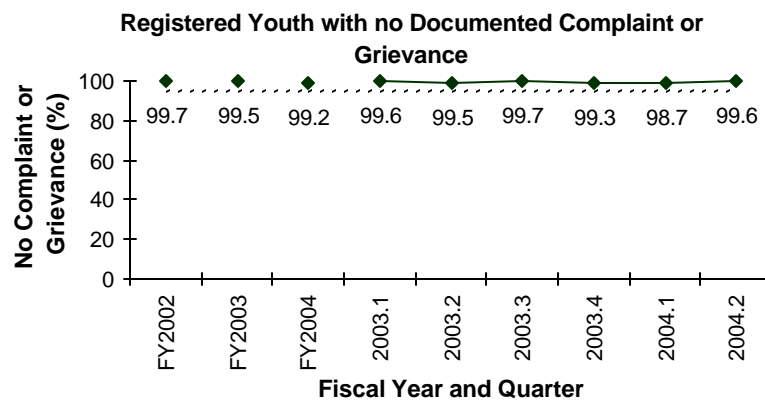
quarter of FY2004 and six in the last quarter of FY2003), indicating this complex is an outlier compared to statewide trends. The remaining nine complexes had one mismatch. Analysis of the situation has found that Baldwin Complex's mismatches are attributed to a shortage of intensive in-home providers on Maui. The provider agency on Maui has been unsuccessful in recruiting an adequate numbers of clinicians. A discussion with the provider is scheduled to assess capacity to provide the scope of services.

*CAMHD will  
timely and  
effectively respond  
to stakeholders'  
concerns*

**Goal:**

⇒ 95% of youth served have no documented complaint received\*

99.6% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers.

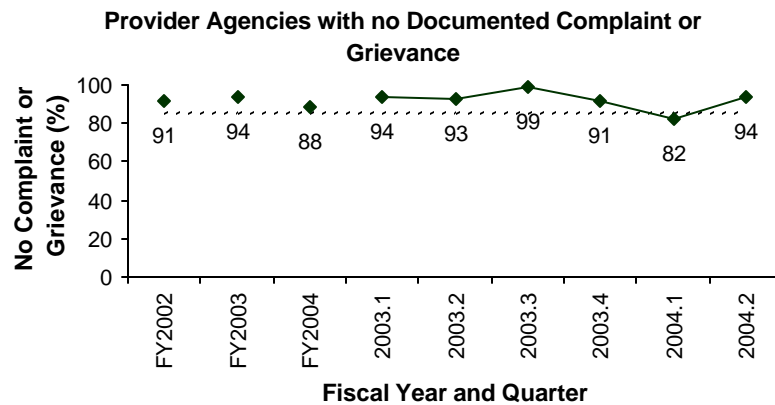


There were 9 youth with documented complaints representing 9 complexes statewide. This compares to 22 youth with documented complaints representing thirteen complexes last quarter. The complexes that each had one documented complaint this quarter were Kailua, Roosevelt, Waipahu, Campbell, Nanakuli, King Kekaulike, Hilo, Keaau, and Kealakehe.

**Goal:**

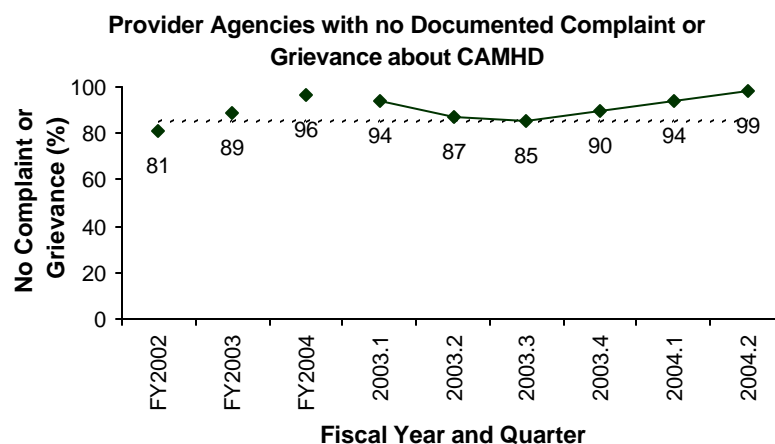
- ⇒ 85% of provider agencies have no documented complaint received\*

94% of provider agencies had no documented complaint about their services meeting the performance goal. This was an improvement over the previous quarter, and reflects the continued positive trend over the past several years.

**Goal:**

- ⇒ 85% of provider agencies will have no documented complaint about CAMHD performance\*

In the quarter, 99% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. This measure has consistently met the performance goal since the beginning of FY2003.

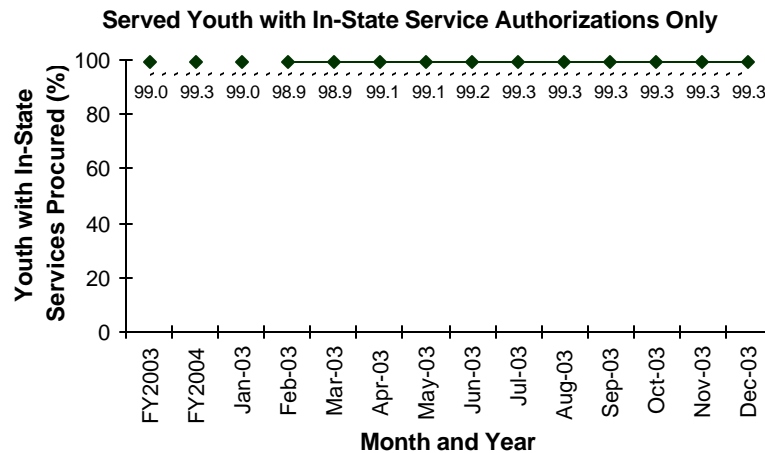


*Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting*

**Goal:**

⇒ 95% of youth receive treatment within the State of Hawaii\*

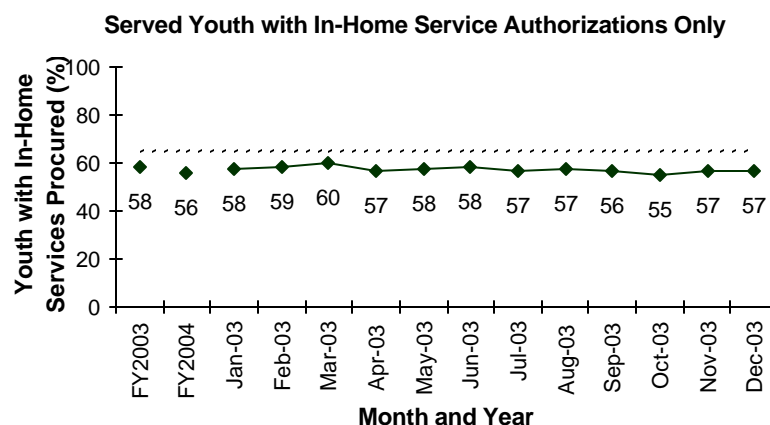
In the quarter, an average of 99.3% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Five youth received services in out-of state treatment settings in the quarter, which is the same as the previous three quarters.



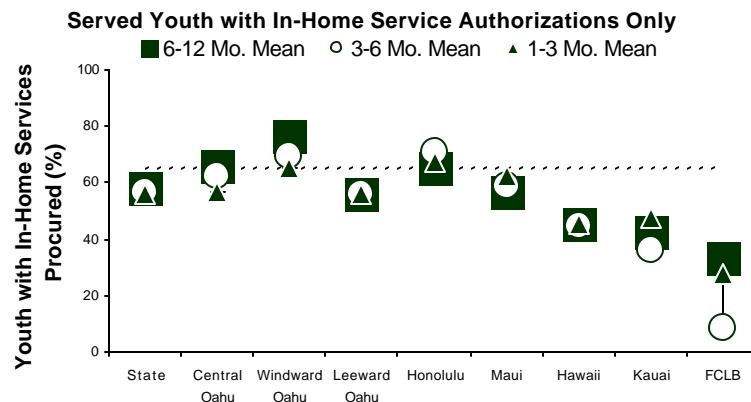
**Goal:**

⇒ 65% of youth are able to receive treatment while living in their home

The quarter's data showed that an average of 56% of youth were served in their home communities throughout the quarter, which was short of the performance goal of 65%. The goal was met for Honolulu FGC and, and nearly met for Windward and Maui FGCs.



As reported in last quarter's report, the performance goal has been adjusted to reflect the actual service utilization patterns of youth with intensive needs as has been discussed extensively in past reports. The baseline trend for youth receiving services while living in their homes averaged 58% of the CAMHD population throughout FY 2003. As seen below, there continues to be variable performance in meeting this goal across the Family Guidance Centers.



Note: Because FCLB provides many direct services rather than procuring services, these proportions are expected to have greater variability and the mean levels are not directly comparable to the other centers.

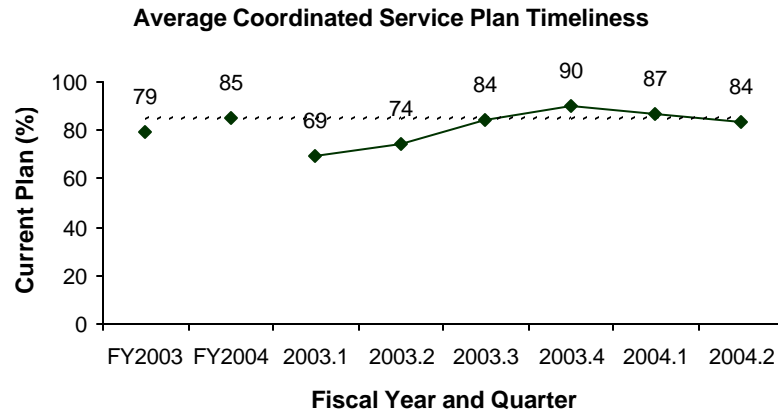
*CAMHD will consistently implement an individualized, child and family centered planning process*

**Goal:**

⇒ 85% of youth have a current Coordinated Service Plan (CSP)\*

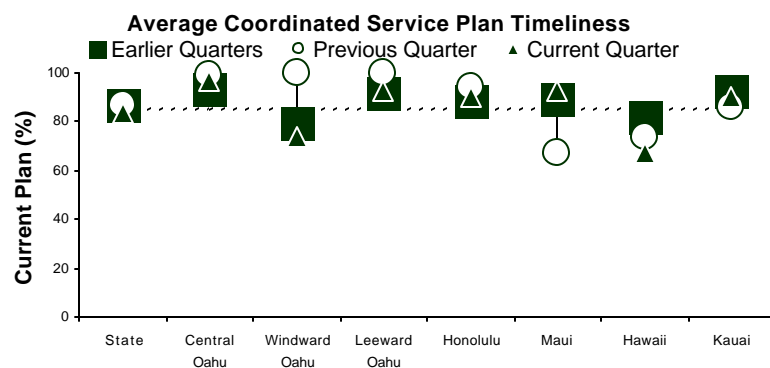
CAMHD's performance in this measure was just short of the performance goal for the reporting quarter as 84% of youth across the state had a current CSP.

Until now "current" was defined as having been established or reviewed at a minimum within the last quarter, with adjustments or revisions to reflect the child's current situation as often as necessary. After extensive review of this practice, CAMHD will move to define "current" as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness will still continue. The change of the definition of "current" is based on the lack of increased value of having more frequent CSP reviews. This was weighed against the desire to have care coordinators spend more time implementing and coordinating plans, versus convening team meetings, which is a considerable undertaking for youth with complex needs. The standard of convening team meetings at any time should there be a need to review or change service strategies remains in effect.



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed.

All of the Family Guidance Centers with the exception of the Hawaii FGC and the Windward Oahu FGC met the performance goal. These data were referred to the FGC Quality Assurance Committees for analysis and development of improvement strategies. Because Hawaii FGC has experienced performance under expectations for the past several quarters, focused efforts have been implemented to assure timely plans. Strategies to increase timeliness of CSPs for the Hawaii FGC include intensive support to the Mental Health Supervisors from the Branch Chief; action plans to prioritize projects for areas that are short-staffed, and moving to fill vacancies. Windward FGC attributes the drop in timeliness since the last quarter (100% in the 1<sup>st</sup> quarter of FY 2004 versus 74% in the 2<sup>d</sup> quarter) to new vacancies in their Kaneohe/Kailua unit. The reassignment of care coordination for the affected youth resulted in delays in CSP reviews. WOFGC has also noticed a tendency for staff to schedule CSP reviews late in the quarter versus staggering the schedule over time. WOFGC has developed supervision strategies to monitor this trend and ensure more timely CSP reviews. It remains the expectation per CAMHD policy that any newly registered youth receive an initial Coordinated Service Plan within 30 days of enrollment.

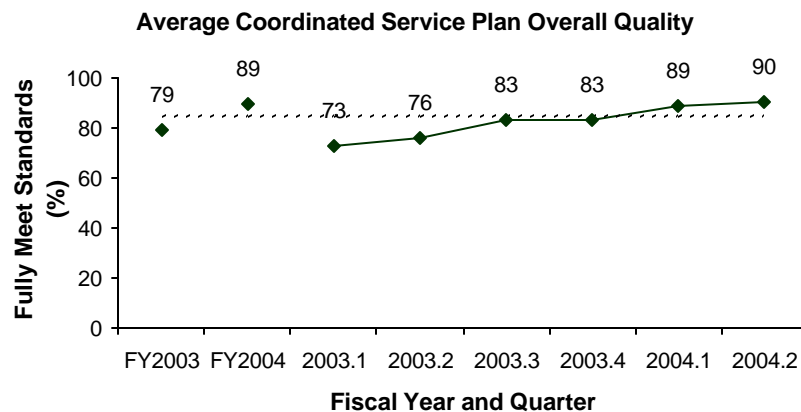


**Goal:**

- ⇒ 85% of Coordinated Service Plan review indicators meet quality standards\*

Reviews of CSPs against quality standards are conducted quarterly in each FGC. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, a clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and other key measures. The goal for this measure was met in the reporting quarter with 90% of CSPs sampled meeting overall standards for quality. The goal was met or exceeded by all FGCs with the exception of Leeward FGC.

The statewide data for quality of CSPs are displayed below:



Leeward's CSP quality has an improving trend, but data indicate a continued need for improved CSP quality. These issues have been forwarded to the CAMHD Practice Development Section and Leeward FGC's Quality Assurance Committee.

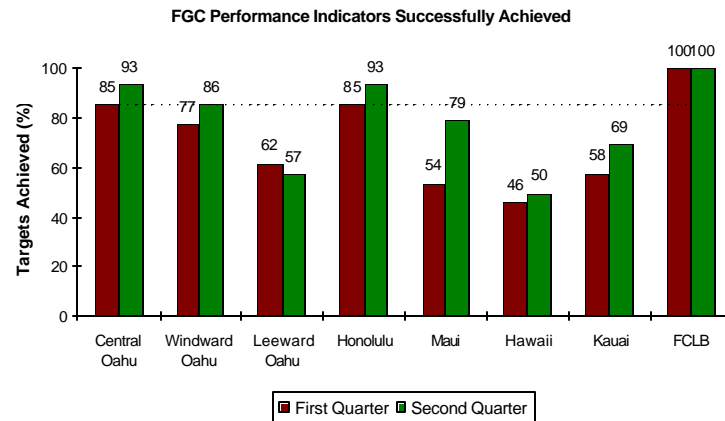
*Mental Health Services will be provided by an array of quality provider agencies*

**Goal:**

- ⇒ 85% of performance indicators are met for each Family Guidance Center

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: expenditures within budget, grievances, access to services (service gaps/mismatches, least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, and improvements in child status.

The goal of meeting 85% of the performance indicators was met by Central Oahu, Windward, Honolulu and Family Court Liaison Branch (FCLB) FGCs. This is the second quarter to date that all goals have been met by three or more FGCs. On average across all FGCs, 78% of all goals were met in the quarter, compared to 70% in the last quarter, and 55% in the first quarter of FY 2003

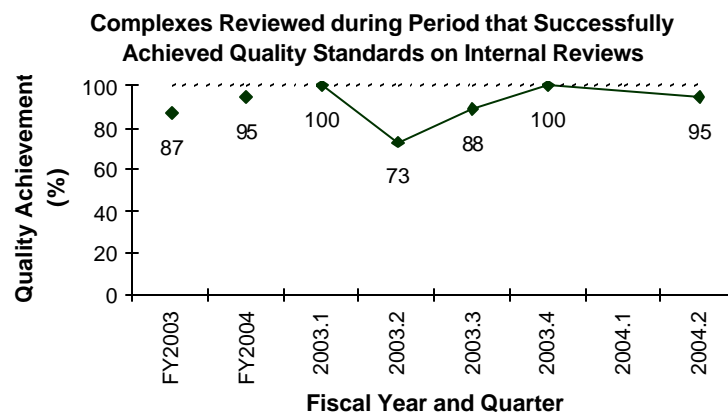


Any performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed through their internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. The FGC management team tracks the implementation of each improvement strategy.

**Goal:**

- ⇒ 100% of complexes will maintain acceptable scoring on internal reviews\*

Of the complexes reviewed in the second quarter, 95% met the performance goal. Nineteen complexes were reviewed in the second quarter and only one, Campbell Complex, did not meet the goal. Acceptable scoring continues to be defined as achieving acceptable system performance for 85% of cases reviewed.



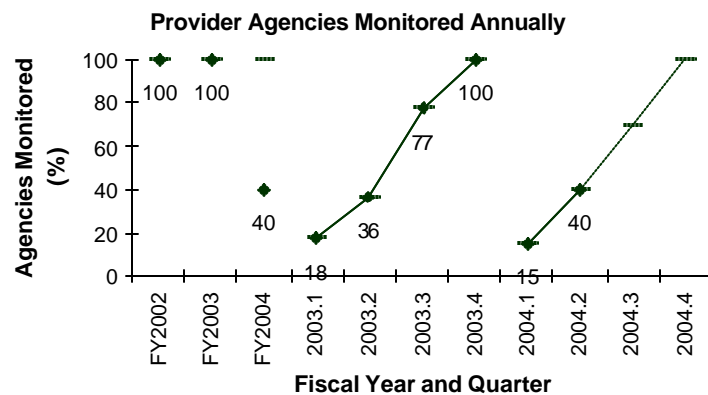
The performance target is for 100% of complexes to meet the goal for acceptable system performance. Campbell fell just short of the goal, scoring 84% on system performance. The complex has developed an improvement plan, which will be monitored for implementation.

*Mental Health Services will be provided by an array of quality provider agencies*

**Goal:**

⇒ 100% of provider agencies are monitored annually

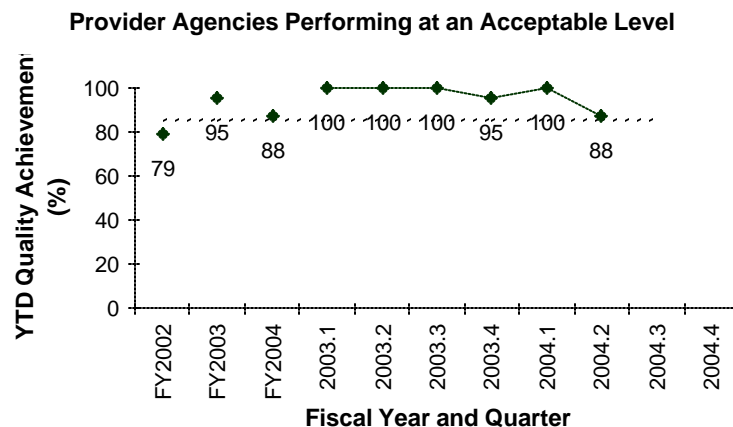
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. Programmatic reviews, including case-based reviews, allow for a focused examination of safe and effective practices. In the quarter, 100% of all agencies contracted to provide direct mental health services were monitored as scheduled, which represents 40% of the annual goal. Six agencies, representing ten contracts and five levels of care, were monitored in the second quarter.



**Goal:**

⇒ 85% of provider agencies are rated as performing at an acceptable level

In the reporting quarter, 88% of the provider agencies reviewed were found to be performing at an acceptable level, meeting the goal for this measure. Provider agencies are reviewed across multiple dimensions of quality and effective practices.

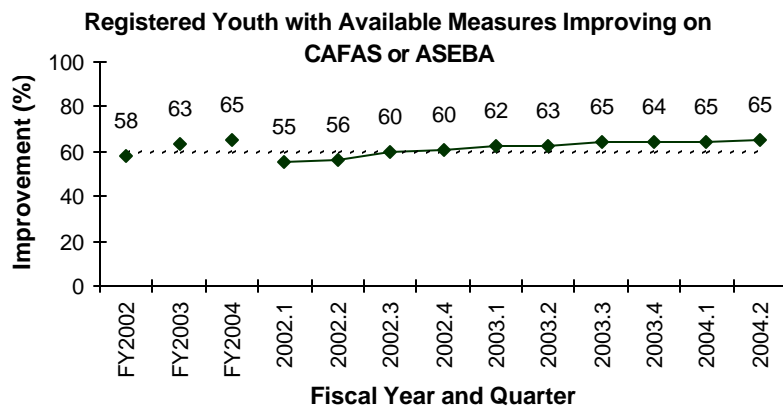


**CAMHD will demonstrate improvements in child status**

**Goal:**

- ⇒ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)\*

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to complete the CAFAS and Achenbach (ASEBA) for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.

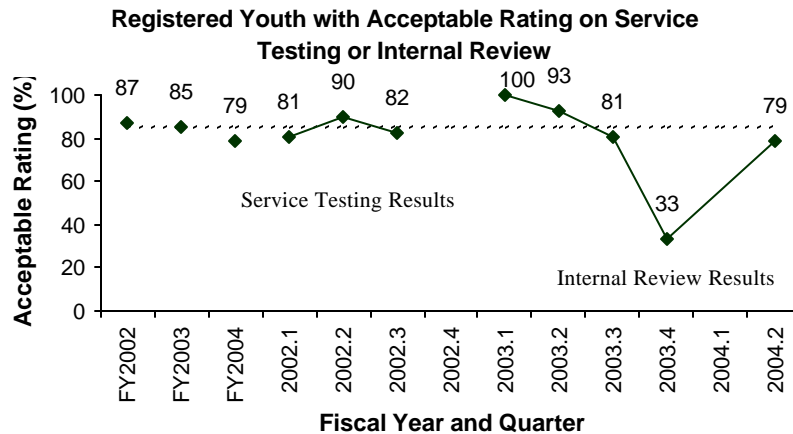


In the reporting quarter, for youth with data for these measures, 65% of youth were showing improvements since entering the CAMHD system, which meets the performance goal. There has been a steady upward trend in functional improvements for youth served by CAMHD. Child functioning as measured by these scales has improved by 5% since the end of FY 2002.

**Goal:**

- ⇒ 85% of those with case-based reviews show acceptable child status

Of youth receiving care coordination and services through CAMHD 79% were found to be doing well against measures of child well-being. This is a considerable improvement since the last reporting quarter (May-June 2003), when child status for youth registered with CAMHD was at 33% acceptable status, but falls short of CAMHD's goal of 85% of youth doing well in child status. Each child with unacceptable child status ratings are referred to their FGC clinical team for review of factors impacting well-being.



*Families will be engaged as partners in the planning process*

**Goal:**

- ⇒ 85% of families surveyed report satisfaction with CAMHD services

As discussed in last quarter's report, CAMHD has decided to change its consumer survey process for FY 2004. Rather than surveying families quarterly in collaboration with HFAA, CAMHD has contracted with a professional, NCQA certified health research vendor. Several factors prompted this decision. First, more and more families have refused to complete the survey as they have been contacted multiple times within the year. Second, Med-Quest Division is requiring administration of the Experience of Care and Health Outcomes (ECHO) survey on an annual basis for Quest-involved youth. CAMHD expects that the use of the ECHO survey with the NCQA protocol will provide higher quality, albeit less frequent information on family perceptions. Therefore, reporting on family satisfaction will move to annual reporting starting in July, 2004.

*There will be state-level quality performance that ensures effective infrastructure to support the system*

**Goal:**

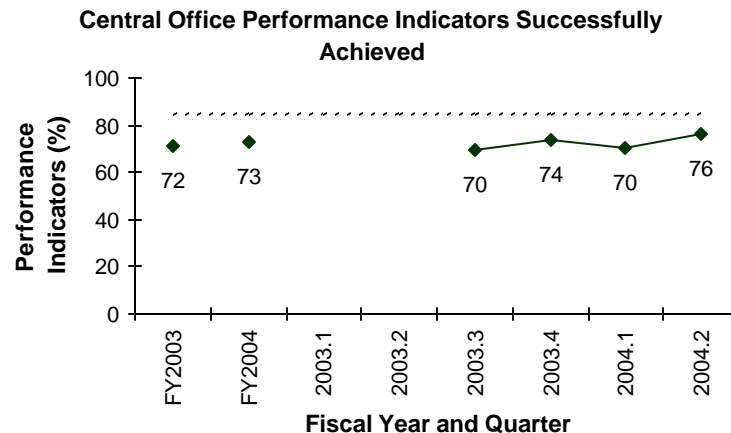
- ⇒ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section under the Clinical Services, Performance Management and Administrative Offices as an accountability and planning tool. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT), and are reported monthly or quarterly depending on the measure. A total of thirty-five measures are tracked. Performance results and trends are discussed and strategies are developed to sustain or improve performance. There are a total of 37 measures currently tracked by EEMT. Over time, measures may be graduated, and new measures selected based on strategic initiatives and priorities of the organization.

In the reporting quarter, 76% of measures were successfully met. This compares to last quarter's results of 70%. For each indicator that falls below its performance target, the managers in the respective section examine results. Improvement strategies are established and

tracked for implementation. For example, when monitoring reports are not completed within timelines, the performance measure for the Program Monitoring Section, the manager must assess all variables impacting the measure.

If solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.

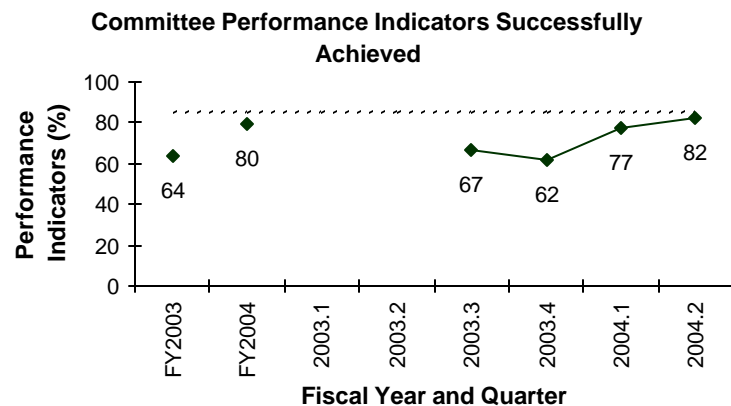


**Goal:**

- ⇒ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Credentialing, Safety and Risk Management, Grievance and Appeals, Utilization Management, Evidence-based Services, Compliance, Information Systems Design, and Training. A total of thirteen measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to select specific improvement strategies that are implemented by respective CAMHD section managers.

In the quarter 82% of performance goals were met through the work of the CAMHD Committees, the best performance in PISC measures to date. Focused improvement initiatives continue to have an impact on improved performance in a number of areas.



## Summary

The majority of performance goals were met or exceeded in the fourth quarter. The asterisked measures are those linked to demonstration of sustainability of efforts under the Felix Consent Decree process. Of the sustainability measures, all indicators fully met the performance goal in the reporting quarter except for filled care coordinator positions which was 3% below targeted performance, and Coordinated Service Plan Timeliness, which was only 1% below target. Several of the non-core measures were also below benchmark. The areas of strength are in the areas of central office infrastructure capacity, funding, timely access to services, system responsiveness to stakeholder concerns, serving youth within the State, quality service plans, and quality service provision.

The following were measures that met or exceeded goals:

- Filled central office positions\*
- Care coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Youth receiving services within 30 days of request\*
- Youth receiving the specific services identified on their plan\*
- Timely and effective response to stakeholder concerns:\*\*\*
  - Youth with no documented complaint received
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance
- Youth receiving treatment within the State of Hawaii\*
- Coordinated Service Plan quality\*
- Central, Windward, Honolulu and FCLB FGC performance goals
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA\*

The indicator newly meeting performance targets was Windward FGC achieving 86% of its performance goals.

The following measures demonstrated a stable or improving trends, but did not achieve the targeted goal:

- Youth receiving treatment while living in their homes
- Family Guidance Center performance indicators
- Complexes reviewed during the period that maintained acceptable scoring on Internal Review\*
- Central Office performance indicators

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies as discussed in the body of this report:

- Filled Care Coordinator positions\*
- Coordinated Service Plan timeliness\*
- Child Status as measured by Internal Review Results

Family Satisfaction data, as discussed in this report, will be reported on at the end of the fiscal year following receipt of data from external evaluation by Omni-Track.

For each measure below its targeted goal, a full analysis of factors affecting performance is routinely conducted, and recommendations for improvement are implemented through PISC and the CAMHD management team.

The reporting period experienced a continued trend in demonstrating sustainability of services and service-delivery infrastructure. All measures of sustainability were either met, or represent a stable and improving trend. Performance management of service delivery and infrastructure are integral to CAMHD operations and organizational culture at all levels, allowing CAMHD to detect and make corrections quickly and assure high-quality, effective services. CAMHD recently completed its Annual Evaluation Report, which provided detailed analysis and review of the information gathered during the annual evaluation process. A key finding of the report shows that over the last three fiscal years (July 1, 2000 to June 30, 2003) the CAMHD service system effectively helped the majority of its youth to experience improved functioning and decreased service needs that prepared them for successful management in outpatient services within a nine to eighteen month service episode. The core elements of practice, infrastructure and performance management have supported development of a stable, vital system of children's mental health services. Sustainability of these practices and systems are a central commitment of CAMHD for the continued realization of positive results for children and families in Hawaii.